U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 09 February 2005

IN THE MATTERS OF:

DELORES L. ASHMORE (as widow of and
behalf of deceased miner Merrill D. Lambright),
Claimant,

v.

Case Nos.: 2004-BLA-93
(formerly 2004-BLA-71)
2004-BLA-5960
(formerly 2004-BLA-5698)

BRIDGER COAL CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES: Delores L. Ashmore, *pro se*

Ronald Gilbertson, Esq.
For the Employer

BEFORE: Thomas M. Burke
Associate Chief Administrative Law Judge

DECISION AND ORDER AWARDING LIVING MINER'S AND SURVIVOR'S BENEFITS

The miner's and survivor's claims arise under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C. § 901 *et seq.* ("Act"), and the implementing regulations thereunder at 20 C.F.R. Parts 718 and 725 (2001). A hearing was held in Denver, Colorado on July 19, 2004. The decision in this matter is based on the testimony of Claimant and her son at the hearing, all documentary evidence admitted into the record at the hearing, and the post-hearing arguments of the parties. The documentary evidence admitted at the hearing is *Director's Exhibits* (*Dx.*) 1-86 and *Employer's Exhibits (Ex.)* 1-4.

Overview of the Black Lung Benefits Program

The Black Lung Benefits Act is designed to compensate those miners who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in the Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dust over a period of time, may contract black lung disease. This disease may eventually render the miner totally disabled or contribute to his death.

Procedural History

1. The miner filed a claim for benefits on March 19, 1998. *Dx.* 1. He noted that he was still working as a coal mine welder at the time. *Dx.* 2.

2. By letter dated September 4, 1998, the Human Resources Manager for Bridger Coal Company stated that the miner's last day of work was June 26, 1998. *Dx.* 4.

3. A *Certificate of Marriage* establishes that the miner married Claimant on April 9, 1992. *Dx.* 9.

4. On December 21, 1998, the district director issued a *Proposed Decision and Order* awarding benefits on the miner's claim. *Dx.* 27.

5. On February 23, 2001, the district director suspended the payment of benefits as the result of Employer's petition for modification after finding that, although the miner suffered from coal workers' pneumoconiosis and was totally disabled, the medical evidence did not support a finding that the miner's disability was due to the disease. *Dx.* 51.

6. By letter dated March 14, 2001, the miner requested a hearing. *Dx.* 52.

7. The miner died on January 31, 2002. *Dx.* 61.

8. A *Certificate of Death* dated February 26, 2002 states that the miner died on January 31, 2002 as the result of complicated coal workers' pneumoconiosis, progressive massive fibrosis, black lung disease, and silicosis. *Dx.* 64.

9. Claimant filed for survivor's benefits on March 19, 2002. *Dx.* 63.

10. On August 30, 2002, the district director issued a *Proposed Decision and Order* awarding benefits on the miner's claim after reviewing additional medical evidence, including an autopsy report. *Dx.* 61.

10. By letter dated September 16, 2002, Employer requested a hearing on the miner's claim. *Dx.* 62.

11. By *Proposed Decision and Order* dated January 16, 2003, the district director awarded survivor's benefits. *Dx.* 73.

12. By letter dated February 6, 2003, Employer filed an autopsy review from Dr. Erica Crouch and requested a hearing on the survivor's claim. *Dx.* 74.

13. A *Revised Proposed Decision and Order* awarding survivor's benefits was issued on February 13, 2003. *Dx.* 75.

14. On March 10, 2003, Employer again requested a hearing. *Dx.* 76.

15. The claims were referred to this Office for hearing on December 19, 2003. *Dx.* 77-78.

Issues Presented for Adjudication and Stipulations

The issues listed as contested on the CM-1025 include: (1) whether the miner suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) whether he is totally disabled; (4) whether the miner's total disability was due to pneumoconiosis; and (5) whether pneumoconiosis hastened the miner's death. *Dx.* 85.

Employer stipulated to 20 years of coal mine employment at the hearing. *Hearing Transcript (Tr.)* at 9.

Moreover, in compliance with the requirements at 20 C.F.R. § 725.414 (2001) applicable to the survivor's claim, Employer will rely on Dr. Tomashefski's autopsy report for case-in-chief. Claimant will rely on the report of Dr. Doberman. *Tr.* at 30. Because the miner's claim was filed prior to the effective date of the amended regulations, there are no applicable evidentiary limitations and the undersigned Administrative Law Judge will consider all autopsy evidence of record (including the report of Dr. Erica Crouch) in the miner's claim.

The Standard for Entitlement

Because this claim was filed after April 1, 1980, it is governed by the regulations at 20 C.F.R. Part 718 (2001).[1] Under Part 718, Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) he suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) he is totally disabled; (4) his total disability is caused by pneumoconiosis; and (5) the miner's death was hastened by pneumoconiosis. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986)(en banc); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986)(en banc). Failure to establish any one these elements precludes entitlement to benefits.

[1] As the miner last engaged in coal mine employment in the State of Wyoming, appellate jurisdiction of this matter lies with the Tenth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(en banc).

Testimony at the Hearing

Delores Ashmore

1. Claimant testified that she had been married to the miner for 11 years. *Tr.* at 8.

2. She stated that her husband passed away on January 31, 2002. *Tr.* at 8.

3. The miner stopped working in the coal mines around June of 1998. *Tr.* at 10-11.

4. In the last three years of his life, the miner "couldn't breathe" and he had headaches and chest pain. *Tr.* at 12.

5. One to two years prior to his death, the miner was bedridden. *Tr.* at 12.

6. According to Claimant, when the miner came home from work, "he had coal up his nose, ears, and everything, still after he took a bath." *Tr.* at 14.

7. Claimant testified that the miner smoked cigarettes from the age of 16 years until 1984, when he was 40 years old (a total of 24 years). *Tr.* at 16.

8. On cross-examination, Claimant testified that the miner was not still smoking in 1995, contrary to his hospitalization and treatment records, because Claimant stated that the miner did not have money for cigarettes after she married him. *Tr.* at 18. Claimant argued that her husband was "not mentally there" when he told doctors that he smoked from the age of 7 years until 1995. *Tr.* at 17.

Brian Ashmore

1. Delores Ashmore is the mother of Brian Ashmore and Merrill Lambright was his stepfather. *Tr.* at 21.

2. Mr. Ashmore testified that, in the last year of his life, the miner's breathing "went down really bad 'cause they had a oxygen tank with a long hose that would go anywhere in the trailer." *Tr.* at 21.

3. Mr. Ashmore stated that his stepfather worked as a welder and that "he said he always took the dangerous jobs, you know, the high risk jobs . . . because it paid more money." *Tr.* at 25.

Existence of Pneumoconiosis and its Etiology

Under the amended regulations, "pneumoconiosis" is defined to include both clinical and legal pneumoconiosis:

(a) For the purpose of the Act, "pneumoconiosis" means a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. The definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2001). Moreover, the regulations at 20 C.F.R. § 718.203(b) (2001) provide that, if a miner suffers from pneumoconiosis and has engaged in coal mine employment for ten years or more, as in this case, there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a) (2001).[3]

[3] There is no autopsy or biopsy evidence in this record and the presumptions contained at §§ 718.304 - 718.306 are inapplicable such that these methods of demonstrating pneumoconiosis will not be discussed further.

When weighing chest x-ray evidence, the provisions at 20 C.F.R. § 718.202(a)(1) (2001) require that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."[4] In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). The following chest roentgenogram evidence is in the record:[5]

Exhibit / Physician/ Radiological Qualifications	***Date of study/ Date of reading***	***Film Quality***	***Reading***
Dx. 24 Gotthoffer radiologist	10-28-95 10-28-95	readable	--; chronic obstructive pulmonary disease with an interstitial reticular nodular patter; no pleural effusion
Dx. 25 Scott B, BCR	10-28-95 11-06-98	2	--
Dx. 25 Wheeler B, BCR	10-28-95 11-07-98	2	--
Dx. 46 Jones B	04-24-98 11-15-98	1	1/0
Dx. 14 Preger B, BCR	04-24-98 05-26-98	2	1/0
Dx. 15 Molton BCR	04-24-98 04-24-98	1	1/1
Dx. 23 Scott B, BCR	04-24-98 09-29-98	2	--
Dx. 23 Wheeler B, BCR	04-24-98 09-30-98	2	--
Dx. 28 Scott B, BCR	10-15-98 12-08-98	2	Completely negative

[4] A"B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

[5] A "--" under the *Reading* column of the chart indicates that the physician did not provide a specific category reading under the ILO-U/C classification system. 20 C.F.R. §§ 718.102 and 718.202(a)(1) (2001).

Dx. 28 Wheeler B, BCR	10-15-98 12-11-98	1	--
Dx. 45 Scott B, BCR	12-09-99 03-21-00	3	--
Dx. 45 Wheeler B, BCR	12-09-99 03-21-00	2	--
Dx. 45 James B	12-09-99 12-10-99	1	0/1
Dx. 53 Lynch Radiologist	08-22-00 08-22-00	readable	--; parenchymal nodularity consistent with pneumoconiosis although lack of upper zone prominence
Dx. 53 Lynch Radiologist	10-06-00 10-06-00	readable	--; not evident complications from coal mine employment
Dx. 61 Scott B, BCR	09-10-01 03-26-02	2	--
Ex. 4 Moore Radiologist	09-10-01 09-10-01	readable	--; "subtle and non-specific interstitial markings"
Dx. 61 Wheeler B, BCR	09-10-01 03-27-02	2	--; no silicosis or coal workers' pneumoconiosis
Dx. 61 Scott B, BCR	10-02-01 03-26-02	2	--
Dx. 61 Wheeler B, BCR	10-02-01 03-27-02	2	--; no silicosis or coal workers' pneumoconiosis
Ex. 4 Burke Radiologist	12-25-01 12-25-01	readable	--; chronic obstructive pulmonary disease; slight prominent interstitial markings in each lower lung; stable chest; no acute abnormality noted

Based on the foregoing, Claimant has not established that the miner suffered from pneumoconiosis by a preponderance of the chest x-ray evidence. Specifically, the October 1995 study did not yield any positive interpretations. The next study, conducted nearly three years later on April 24, 1998, produced Category 1 readings by a B-reader, a board-certified radiologist, and a dually-qualified physician. Two dually-qualified physicians did not find the presence of pneumoconiosis on the study. Pneumoconiosis is not established through the April 1998 study because a majority of the dually-qualified physicians did not find the disease present. Moreover, none of the remaining studies of record, dated October 1998, December 1999, August

2000, October 2000, September 2001, October 2001, and December 2001 yielded positive findings of pneumoconiosis. On balance, the chest x-ray evidence does not support a finding of the disease.

Pursuant to 20 C.F.R. § 718.202(a)(2) (2001), pneumoconiosis may be established through biopsy or autopsy evidence, which is submitted in accordance with the quality standards at 20 C.F.R. § 718.106 (2001) of the regulations. The following autopsy evidence is in the record:

1. Dr. Michael J. Doberson conducted an autopsy of the miner and issued a report on February 23, 2002. *Dx.* 65. His pathological diagnosis contained a number of findings, including complicated coal workers' pneumoconiosis, progressive massive fibrosis, silicosis, extensive anthracosis, focal silicotic nodules of the bilateral lungs, centrilobular emphysema with extensive scarring, chronic pulmonary hypertension and pulmonary artery atherosclerosis, chronic cor pulmonale with cardiomegaly and right ventricular dilation, congestive heart failure, central necrosis of the liver, acute bronchopneumonia, and arteriosclerotic cardiovascular disease. Dr. Doberson concluded the following:

> This 56 year old man with a history of end stage lung disease died while in a nursing home. His medical history is remarkable for occupational exposure to coal dust. At autopsy, there were no injuries which could be considered to be a contributing cause of death. His death is attributed to complications of complicated coal workers' pneumoconiosis (progressive massive fibrosis) also known as black lung disease. A component of silicosis was also apparent. Evidence of severe cor pulmonale was seen at autopsy.

Macroscopic findings were that pleural surfaces were remarkable for extensive anthracosis and extensive adhesions. Dr. Doberman noted:

> Cut surfaces show extensive anthracosis with focal irregular areas of anthracotic scarring, some of which measure up to 2 ½ inches in greatest dimension. A pattern of centrilobular emphysema is evident. There is also generalized severe edema as well as focal areas of consolidation consistent with acute bronchopneumonia.

Microscopic findings included complicated coal workers' pneumoconiosis characterized by centrilobular emphysema and extensive anthracosis. Dr. Doberman further noted "features of silicosis consisting of collagenous silicotic nodules which contain(ed) birefringent polarizable material consistent with silica." He observed that the lymph nodes contained "extensive anthracosis and collagenous silicotic nodules . . .."

Dr. Doberman is board-certified in anatomic, clinical, and forensic pathology. He also serves as a coroner and medical examiner.

2. Dr. Erika C. Crouch conducted a review of the autopsy slides, prosector's report, and certain other medical records and issued an opinion on December 3, 2002. *Ex.* 3. On the slides,

Dr. Crouch noted "areas of acute bronchopneumonia superimposed on the lung with mild centriacinar emphysema." She further found a "few small macules characterized by dust-containing macrophages and variable associated fibrosis," "scattered granulomatous lesions," and a "focus of focal emphysema." Dr. Crouch noted that, "[a]lthough there is some coalescence of the hyalinizing subpleural lesions, no coal dust micronodules or nodules or larger silicotic nodules are identified." She stated that the "most striking abnormalities relate to the pulmonary vasculature, particularly the pulmonary arteries," which could not be attributed to the miner's pneumoconiosis. Rather, Dr. Crouch concluded:

> The severity of the vascular disease is consistent with the gross findings of right ventricular hypertrophy and dilation as well as other findings consistent with right heart failure.

Indeed, Dr. Crouch opined that the pattern of histologic changes "strongly favors a primary pulmonary hypertensive disorder and rules against hypoxemic pulmonary hypertension secondary to dust-related lung disease." Dr. Crouch concluded that the miner suffered from simple coal workers' pneumoconiosis and simple siderosis arising from welding as well as centriacinar emphysema, acute bronchopneumonia, and changes consistent with severe pulmonary hypertension. Dr. Crouch observed no areas of "massive fibrosis or complicated silicosis" and she noted that the "lesions are relatively small in size and number." She stated that the miner's coal dust-related changes were:

> . . . insufficient to have caused any clinically significant degree of functional impairment or disability and did not significantly contribute to the observed pulmonary vascular abnormalities and pulmonary hypertension. Death can most reasonably attributed to acute pneumonia developing in the setting of cardiac failure and cor pulmonale resulting from severe pulmonary hypertension.

Dr. Crouch is a Professor of Pathology and Immunology at the Washington University of St. Louis School of Medicine. She is board-certified in anatomic pathology.

3. Dr. Joseph Tomashefski conducted a review of the autopsy slides and report as well as certain other medical records and issued an opinion on May 22, 2003. *Ex.* 2. He noted that, while the prosector found complicated pneumoconiosis, the largest nodule on the slides measured .8 x .2 centimeters in diameter. Dr. Tomashefski further found minimal, non-specific interstitial fibrosis present on the slides as well as mild, simple coal workers' pneumoconiosis, mild centriacinar emphysema, and focal acute bronchopneumonia. He concluded that the major histological finding was severe pulmonary hypertensive vascular disease. Dr. Tomashefski reported a "complicated occupational history" where the miner worked as a "gravel crusher" from 1968 to 1969, he worked in a construction and chemical plant from 1970 to 1972 "with possible exposures to asbestos and chlorine", and from 1977 to 1998, he worked as a coal miner and his last job was that of welder.

Dr. Tomashefski reviewed the slides and noted "relatively well-preserved alveolar architecture, without significant fibrosis." He observed scattered, irregular, and fibrohyaline nodules containing birefringent particles consistent with silica and silicates. He also found

minimal, nonspecific interstitial fibrosis. Dr. Tomashefski stated that the "most striking feature of the slides are pulmonary artery changes which are consistent with severe pulmonary hypertension."

Dr. Tomashefski concluded that the miner suffered from mild simple coal workers' pneumoconiosis and mild centriacinar emphysema. He concluded that these two conditions could not "explain the severe pulmonary hypertension and cor pulmonale" suffered by the miner. He further stated:

> The degree and pattern of pulmonary hypertensive vascular disease, likewise, is not typical of that seen in sleep apnea syndrome. In my opinion, Mr. Lambright's severe pulmonary hypertension is most consistent with primary pulmonary hypertension.

Dr. Tomashefski concluded that complicated coal workers' pneumoconiosis was not present as the largest coalescent, pneumoconiotic lesion seen on the autopsy slides measured less than two centimeters in diameter and was below the minimum size required for a diagnosis of complicated pneumoconiosis. He opined that the miner's simple coal workers' pneumoconiosis was too mild to cause respiratory symptoms or respiratory impairment and it did not cause or contribute to his death.

Dr. Tomshefski is Chair of the Pathology Department at the Case Western Reserve University School of Medicine. He is board-certified in clinical and anatomical pathology.

All of the pathologists agree that the autopsy tissue supports a finding that the miner suffered from simple coal workers' pneumoconiosis. Dr. Doberson, the prosector, also found the presence of complicated coal workers' pneumoconiosis and he specifically described areas of anthracotic scarring measuring "up to 2 ½ inches in greatest diameter."

Drs. Crouch and Tomashefski, on the other hand, conclude that tissue on the autopsy slides did not yield evidence of complicated pneumoconiosis. Dr. Tomashefski concluded that the "largest coalescent, pneumconiotic lesion seen on the autopsy slides measured less than two centimeters in diameter and was below the minimum required for a diagnosis of complicated pneumoconiosis." Dr. Crouch found the tissue slide lesions to be "relatively small in size and number."

Although the Tenth Circuit has upheld according greater weight to the opinion of a prosector over the opinions of reviewing pathologists based on the prosector's first-hand observations of the miner's lungs, *Northern Coal Co. v. Director, OWCP*, 100 F.3d 871 (10th Cir. 1996), Dr. Doberman's report in this case is not accorded greater weight simply because he was the prosector in this case. Rather, given the (1) very specific measurements and detailed findings provided by Dr. Doberman in his autopsy report, including observing a 2.5 inch lesion in the miner's lung that was related coal dust exposure, (2) Dr. Doberman's understanding of the concepts of simple and complicated pneumoconiosis as evidenced by the content of his report, and (3) Dr. Doberman's superior qualifications, *i.e.* board-certification in all three areas of pathology—clinical, anatomical, and forensic—as opposed to the more limited board-

certifications of Drs. Crouch and Tomashefski, it is determined that Dr. Doberman's autopsy findings and report is persuasive that the miner suffered from complicated pneumoconiosis.

Although it is determined that the most probative autopsy evidence supports findings of simple and complicated coal workers' pneumoconiosis, the medical opinion evidence will also be reviewed. Claimant may demonstrate the presence of coal workers' pneumoconiosis based on well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports, which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). The following medical reports were admitted as evidence in the record:

1. Dr. John E. Guicheteau examined and tested the miner and issued a report on June 2, 1998. *Dx.* 11. He noted 20 years of coal mine employment as well as a history of smoking two packs of cigarettes per day from 1952 to 1984, a total of 22 years. Dr. Guicheteau further reported four years of copper mining and one year of lead mining as part of the miner's work history. Examination of the lungs revealed diffuse crackles mid to late inspiration and wheezing on forced expiration. Dr. Guicheteau diagnosed coal workers' pneumoconiosis based on a chest x-ray, mining history, and blood gas study results. He further concluded that the miner was totally disabled due to the disease based on resting and exercise blood gas study results underlying his opinion. The miner's exercise stress test yielded normal values.

2. Dr. Lawrence Repsher examined and tested the miner, reviewed certain medical records, and issued a report on October 20, 1998. *Dx.* 24. He noted 20 years and nine months of coal dust exposure, where the miner retired as a welder on June 26, 1998. Dr. Repsher also reported a history of smoking two packs of cigarettes per day from the time the miner was seven years old until he was 52 years old. He noted that the miner quit smoking in February 1998 "because of severe Berger's disease of his hands." Examination of the lungs revealed no abnormal breath sounds. A chest x-ray was interpreted as negative for the presence of pneumoconiosis. Pulmonary function testing was normal, but blood gas testing produced qualifying values.

Dr. Repsher concluded that the miner did not suffer from coal workers' pneumoconiosis; rather, he had mild to moderate emphysema, secondary to cigarette smoking. Dr. Repsher further stated that the miner had chronic depression and Berger's disease. Finally, he stated that the miner was not totally disabled and his "modest pulmonary function and arterial blood gas

abnormalities are more than adequately explained by his long history of heavy cigarette smoking."

Dr. Repsher conducted a review of Dr. James' report and issued an opinion on March 22, 2000. *Dx.* 45. He disagreed with Dr. James' conclusions, except the finding that coal mine dust exposure was not a contributing factor to development of the miner's hypoxemia. Dr. Repsher concludes that the miner did not suffer from clinical pneumoconiosis based on negative chest x-ray findings. He further states that the miner did not suffer from legal pneumoconiosis. Dr. Repsher opines that "any respiratory impairment or disability is clearly due to (the miner's) long and heavy cigarette smoking habit." He cites to NIOSH studies that have "repeatedly indicated that simple coal workers' pneumoconiosis does not cause impairment of the diffusing capacity." On the other hand, Dr. Repsher states that "cigarette smoking has long been associated with very serious impairment of the diffusing capacity." Finally, Dr. Repsher concludes that Dr. James' interpretations of the December 9, 1999 and April 24, 1998 studies were "not compatible with the diagnosis of any previously described lung disease" and render his report "internally inconsistent."

Dr. Repsher issued a supplemental opinion on January 24, 2000 after reviewing the reports of Drs. James and Branscomb. *Dx.* 45. He repeated his findings that the miner did not suffer from coal workers' pneumoconiosis based on the chest x-ray evidence. Dr. Repsher opined that the blood gas testing did not compel a finding that the miner was totally disabled from performing "continuous heavy manual labor."

Dr. Repsher is board-certified in internal medicine and pulmonary diseases. He is also a B-reader.

3. Dr. Thomas Wilcox examined and tested the miner and issued a report on April 8, 1999. *Dx.* 33. Dr. Wilcox noted a history of "coal miner's pneumoconiosis" and he stated that the miner was being examined for shortness of breath. Dr. Wilcox reported a "40 plus pack year" smoking history where the miner quit 18 months prior to the examination. Examination of the miner's lungs revealed a "few bibasilar crackles but fairly good air movement." Pulmonary function testing produced normal results with "some evidence of small airways obstruction." Dr. Wilcox further noted that the miner's "diffusion capacity (was) markedly reduced even when corrected for alveolar ventilation." Dr. Wilcox concluded that the miner suffered from coal workers' pneumoconiosis, early emphysema, a severe reduction in diffusion capacity, and hypoxia with exercise.

4. Dr. Ben V. Branscomb conducted a review of certain medical records and issued reports on April 14, 1999 and May 3, 2000. *Dx.* 45 and 51. Based on his review of records, Dr. Branscomb concluded that the miner did not suffer from coal workers' pneumoconiosis, but that he was totally disabled from arduous labor "based on his reduced diffusing capacity and the low exercise PO2." Dr. Branscomb attributed the miner's "gas exchange problems to cigarette smoking or Buerger's Disease." He stated that Dr. James' findings of pneumoconiosis based on a chest x-ray were contraindicated by CT-scan evidence. Moreover, Dr. Branscomb noted that Dr. James found only Category u changes, which are not compatible with coal workers' pneumoconiosis because opacities caused by pneumoconiosis are "predominantly p or q." Dr.

Branscomb stated that a preponderance of the chest x-ray evidence was negative for the presence of pneumoconiosis. He asserts that ventilatory testing underlying Dr. James' report was invalid based on the flow-volume loop. Dr. Branscomb agreed with Dr. James that, even if the miner suffered from coal workers' pneumoconiosis, "one cannot attribute the hypoxemia" to the disease because fibrotic changes on x-ray were insufficient to produce hypoxemia." As a result, Dr. Branscomb concluded that the miner suffered from neither clinical or legal pneumoconiosis. He found that the miner was totally disabled based on his reduced diffusing capacity and abnormal blood gas study results. Moreover, Dr. Branscomb maintained that the miner's disability was due to his heavy tobacco exposure and, possibly, Buerger's Disease. He further stated that his opinion would not change even if pneumoconiosis was established by x-ray evidence.

Dr. Branscomb is board-certified in internal medicine.

5. Dr. Leon Cander conducted a review of Dr. Repsher's report and issued an opinion on September 23, 1999. *Dx.* 36. Initially, Dr. Cander stated:

> I believe it is important to note that several statements made by Dr. Repsher are incorrect. In fact, medical research published since 1970 has unequivocally and clearly refuted his fixation upon smoking as the sole cause of emphysema in coal miners.

Dr. Cander maintains that there is literature to support a finding that "coal mine dust is an independent cause of centrilobular (centriacinar) emphysema, separate and distinct from cigarette smoke." He further notes that the miner suffered from hypoxemia and the "most common cause of hypoxemia in patients with lung disease is ventilation-perfusion mismatch." This means that the miner is not able to adequately transfer oxygen into the blood stream. Dr. Cander opined:

> Centrilobular emphysema can and does result in ventilation-perfusion mismatch and is a well-documented cause of hypoxemia which is the cause of the decreased arterial oxygen tension noted both at rest and during exercise in Mr. Lambright.

Finally, Dr. Cander noted that Dr. Repsher's opinion that the miner was not totally disabled was "obviously incorrect and refuted by the objective data."

6. Dr. David James examined and tested the miner, reviewed certain medical records, and issued a report on December 9, 1999. *Dx.* 45. He noted a 20 year history of coal mine employment and that the miner smoked one and one-half a pack of cigarettes per day from the age of 11 years to 52 years. Initially, Dr. James noted that a "chest x-ray revealed several changes that potentially could be related to coal workers' pneumoconiosis." A CT-scan also presented "upper lobe opacities that are consistent with coal workers' pneumoconiosis." He noted, however, that the "number of opacities appears to be few and radiographically (he) would rate this as mild coal workers' pneumoconiosis" such that the x-ray was classified as 0/1. Examination of the lungs was normal. Based on ventilatory testing, which revealed a mild airflow obstruction, Dr. James found that the miner suffered a "mild" obstructive airways

disease, which could be due to "his history of cigarette smoking, exposure to coal mine dust, or exposure to welding fumes." Dr. James further noted that the miner suffered from hypoxemia but he could not determine "with a reasonable degree of medical certainty that Mr. Lambright's coal mine dust exposure was a contributing factor in the development of his hypoxemia." Dr. James concluded that the miner was not totally disabled due to a coal dust induced respiratory disease. He theorized that "[a]lthough the oxygen saturation values were markedly low during the current assessment, the miner's Berger's disease may have interfered with an accurate assessment by pulse oximetry of his oxygen status at rest and with exertion."

Dr. James is an Associate Professor of Medicine at the University of New Mexico School of Medicine. He specializes in pulmonary diseases, allergies, and critical care.

7. Dr. Paul Wheeler, who is a B-reader and board-certified radiologist, concluded that a CT-scan dated December 10, 1999 was negative for the presence of pneumoconiosis. *Dx.* 51. He further noted the presence of "minimal lower pretracheal and hilar adenopathy compatible with inflammatory disease more likely than lymphoma."

8. Dr. Philip Silkoff, staff physician at the National Jewish Medical Center, examined and tested the miner and issued a report on July 28, 2000. *Dx.* 53. He noted that the miner complained of shortness of breath. Dr. Silkoff reported 21 years of coal mine employment and a smoking history of two and one-half packs per day, where the miner quit in 1998. He further noted that the miner was on oxygen therapy. Examination of the lungs revealed mild rales and crackles at both bases with no wheezing. Dr. Silkoff noted that the miner had "multiple occupational exposures and cigarette smoking in the past with more than 100 pack years." He reported that the miner's functional impairment "appears to be significant and severe." Dr. Silkoff recommended additional testing for an "assessment as to the nature of (the miner's) lung disease and whether this is related to his previous exposures."

On August 19, 2000, Dr. Silkoff conducted a sleep study of the miner and diagnosed the presence of obstructive sleep apnea syndrome. *Dx.* 53.

On August 21, 2000, Dr. Silkoff referred the miner to Dr. Debra Dyer for "pulmonary perfusion and pulmonary ventilation" testing. *Dx.* 53. Dr. Dyer reported that there was no evidence of a pulmonary embolism but "[d]elayed Xenon washout (was) consistent with air trapping and obstructive lung disease."

On August 21, 2000, Dr. Silkoff ordered that a CT-scan be conducted. *Dx.* 53. This was interpreted by Dr. David Lynch. Dr. Lynch found the presence of profuse fine nodules in the upper lobes "with a more ground glass pattern in the lower lobes and mild intralobular septal thickening." Dr. Lynch further concluded the following:

> The poorly defined upper lobe nodules could be due to pneumoconiosis, though not typical in appearance. The more patchy ground-glass abnormality at the bases would be atypical for pneumoconiosis. The extent of lymphadenopathy is also atypical, though it does not exclude the diagnosis. Possibility of sarcoidosis should be considered.

Dr. William Scott reviewed the CT-scan and issued a report on April 11, 2001. *Dx.* 57. He found no evidence of silicosis or coal workers' pneumoconiosis, but found a "few scattered blebs" and "scattered, mild bronchrectasis." Dr. Scott further noted "[m]any enlarged lymph nodes which could be either due to inflammatory disease such as histoplasmosis or tuberculosis or neoplastic disease such as metastatic carcinoma or lymphoma." Dr. Paul Wheeler also reviewed the CT-scan and issued a report on April 6, 2001. *Dx.* 57. He found "[m]inimal emphysema with few small subpleural blebs in apices and anterior medial portion." Dr. Scott further observed "[m]any enlarged mediastinal lymph nodes which could be either due to inflammatory disease such as histoplasmosis or tuberculosis or neoplastic disease such as metastatic carcinoma or lymphoma." Dr. Wheeler observed "tiny areas of centrilobular emphysema scattered in the upper lobes" and a "[f]ew tiny blebs and/or bronchiectasis in (the) posterior lower lobes." He also observed a "moderate right inferior paratracheal adenopathy with node measuring 2.8 centimeters in diameter" that was "compatible with inflammatory disease such as sarcoid, TB or histoplasmosis but (he could not) rule out lymphoma."

Dr. Silkoff examined the miner on July 28, 2000 and noted that the miner's "functional impairment appears to be significant and severe." *Dx.* 60. He further reported that pulmonary function testing "suggested an interstitial process rather than an obstructive disease." Examination of the lungs revealed "some mild rales and crackles audible at both bases with no wheezing." Dr. Silkoff noted multiple occupational exposures and a 100 pack year smoking history. Dr. Silkoff's treatment notes are also in the record.

At the request of Dr. Silkoff, a bronchoscopy of the right side was conducted on September 12, 2000 by Dr. Carlyne Cool. *Dx.* 53. Dr. Cool found that the vocal cords and upper airway appeared normal. She noted no excessive bronchial inflammation or secretions. The pathology report noted that "multiple pieces of tan-brown tissue fragments measuring up to 7 x 3 x 2 millimeters in greatest dimension" were received in formalin. No polarizable material was identified and the bronchial wall revealed no diagnostic abnormality. Dr. Cool noted that there was "no evidence of acute of chronic inflammation of the bronchial wall" and she observed no "giant cells or granulomas." A cytology report dated September 13, 2000 by Dr. M. Scott Lucia established that the lung sample was "negative for malignant cells." A lymph node biopsy conducted by Dr. John Ryder demonstrated findings consistent with sarcoidosis.

Dr. Silkoff is a Staff Physician specializing in adult pulmonary medicine.

9. On June 7, 2001, the miner arrived at the hospital via ambulance for shortness of breath. *Dx.* 61. Examination of the lungs revealed "[b]reath sounds decreased (on) both sides" but there was no wheezing, rales, or rhonchi. He was hospitalized for cardiac and breathing problems on in April, June, July, and September of 2001. During his hospitalization on September 26, 2001 for shortness of breath, examination of the lungs revealed decreased breath sounds with no wheezing, rales, or rhonchi.

10. On June 9, 2001, Dr. Jose Pacheco examined the miner and evaluated him for a probable cardiac shunt due to symptoms of increasing dyspnea and fatigue. *Dx.* 62. Dr. Pacheco noted 22 years of coal mine employment and a 30 year smoking history, where the miner quit around

1994 and had a peak smoking habit of four packs per day. Dr. Pacheco further reported that the "patient feels his peak smoking was approximately four packs a day." Examination of the lungs revealed rales and "diffuse rhonchi." A CT-scan demonstrated "diffuse fine nodules in the upper lobes as well as lower lobe infiltrates consistent with either Cushingoid response to failure and/or alveolitis." Dr. Pacheco noted that a "sleep study revealed minor sleep apnea" but Mr. Lambright "had not desaturated for greater than 30 minutes over a 24 hour period." Dr. Pacheco further noted the following:

> The patient also has exercise testing which showed functional dead space versus tidal volume. This improved normally, which would suggest that the patient's desaturation may be due to cardiac disease.

Dr. Pacheco concluded that the miner:

> . . . appears to have an element of an intracardiac shunt. There appears to be right to left shunting present which may well contribute significantly to his chronic hypoxia and to his abnormal DLCO and pulmonary function testing. The patient clinically does not appear to have reactive airway disease, although he does have an element of emphysema and mild air trapping. The pulmonary functions do not seem to substantiate significant enough lung disease to account for this hypoxia. Additionally, the patient's dead space/tidal volume ratio improved with exercise, which again would argue against significant pulmonary disease.

On June 15, 2001, the miner was hospitalized by Dr. Pacheco and was diagnosed with pulmonary hypertension, possible thromboembolic disease, probable pneumoconiosis, pulmonary sarcoidosis, and a possible element of silicosis and emphysema. On September 10, 2001, the miner completed a form for Dr. Pacheco stating that he smoked three packs of cigarettes per year for 30 years until he quit in 1997. The miner was experiencing problems with shortness of breath. He had been diagnosed with sleep apnea and black lung disease and was on oxygen at home.

11. A CT-scan of the miner's chest was conducted on June 13, 2001 and Dr. Michael DeGroot reported that the scan was negative for pulmonary embolus and the lower extremity of the scan was inconclusive for deep venous thrombosis due to imaging technique. *Dx.* 60. Dr. Paul Wheeler also reviewed the CT-scan and issued a report on March 27, 2002. Dr. Wheeler found no evidence of pneumoconiosis and only minimal evidence of emphysema as well as healed pneumonia. He reported "minimal lower paratracheal adenopathy, largest 2 (centimeters) in diameter, compatible with inflammatory disease." Similarly, Dr. William Scott reviewed the CT-scan and, by report dated April 2, 2002, he found only a "few blebs/bullae" in the "anterior upper right lung and posterior lower lungs." He also found "[s]everal minimally-enlarged mediastinal lymph nodes (of) unknown significance" and posited that these nodes could be "post inflammatory or due to malignancy."

12. The miner was referred by the hospital to Dr. Gina Chen on July 27, 2001 for shortness of breath and respiratory distress. *Dx.* 59. Dr. Chen noted that the miner's home oxygen tank had run empty and he was taken by ambulance to the hospital. She reported a 120 pack year

smoking history as well as the fact that the patient was a coal miner. Examination of the lungs revealed "significantly decreased breath sounds and very fine bell like crackles at the bases."

13. On July 20, 2001, the miner was examined and tested by Dr. David Badesh of the Pulmonary Hypertension Clinic. *Dx.* 60. Dr. Badesh reviewed certain medical records and noted unspecified smoking and coal mining histories as well as a history of alcohol abuse. He stated the following:

> Based upon these reports, it would sound as though the possibility of sarcoidosis or perhaps becylosis should also be entertained in the differential diagnosis. As per my previous note, it was our impression that the patient had severe pulmonary hypertension which may be multifactorial in etiology, with possible contributing factors including interstitial lung disease (multiple occupational exposures and the possibility of sarcoidosis versus perhaps berylosis), chronic obstructive pulmonary disease/emphysema (the patient has a long and heavy history of tobacco abuse, as previously mentioned), obstructive sleep apnea, prior amphetamine use, and possibly underlying liver disease (the patient has a long history of heavy alcohol use).

When Dr. Badesh examined the miner on July 3, 2001, he noted that the miner's lungs were "[e]ssentially clear to auscultation" and that the miner used supplemental oxygen at home. *Ex.* 4. He further noted that the miner smoked up to four packs of cigarettes per day and quit four years ago. Dr. Badesh concluded that several factors could have contributed to the miner's "severe pulmonary hypertension" including a smoking history of up to four packs of cigarettes per day, obstructive sleep apnea, alcohol and past amphetamine use (raising the possibility of underlying liver disease), and interstitial lung disease due to multiple occupational exposures.

Dr. Badesh is a Professor of Medicine specializing in pulmonary sciences and critical care at the University of Colorado Hospital.

14. From September 10, 2001 to September 15, 2001, the miner was hospitalized for depleted potassium, worsening hypoxia, and "end-stage obstructive and interstitial lung disease." *Dx.* 59. The miner was hospitalized under the care of Dr. Joseph Anderson from September 26, 2001 to October 4, 2001. *Dx.* 58. He was admitted because of critically low potassium levels. The discharge diagnosis included hypokalemia, pulmonary hypertension with cor pulmonale, black lung, sarcoidosis, and hyperlipidemia.

15. During the miner's last hospitalization from January 23, 2002 until his death on January 31, 2002, he had an abnormal EKG and was diagnosed with chronic obstructive pulmonary disease. *Ex*. 4. Examination of the lungs on January 23rd revealed "rales and rhonchi."

16. By report dated October 31, 2002, Dr. Thomas Hayes, who is a B-reader and board-certified radiologist, concluded that a "limited" CT-scan revealed "no evidence of parenchymal changes to suggest pneumoconiosis." *Dx.* 72. He further noted that the CT-scan "exclude(d) the examination of both upper lobes and apices."

17. Dr. Peter G. Tuteur conducted a review of certain medical records and issued a report on March 22, 2004. *Ex.* 1. He noted all three pathologists in this case found simple coal workers' pneumoconiosis by autopsy and that Dr. Doberson found the presence of complicated coal workers' pneumoconiosis. Dr. Tuteur noted that, during his lifetime, the miner's pulmonary function testing produced non-qualifying values, but the blood gas studies revealed a "marked impairment of gas exchange at rest" that worsened with exercise. Dr. Tuteur concluded that, based on the objective data of record, the miner suffered from simple coal workers' pneumoconiosis "of insufficient severity and profusion to produce clinical symptoms, physiologic impairment, or radiographic change." He concluded that the miner suffered from severe pulmonary hypertension of unknown origin. Moreover, Dr. Tuteur diagnosed the presence of centrilobular emphysema that was too mild to "produce airflow obstruction." He concluded that the miner's coal workers' pneumoconiosis was too insignificant to hasten his death; rather, the miner's death was hastened by pulmonary hypertension of unknown origin.

Dr. Tuteur is an Associate Professor of Medicine and specializes in internal medicine.

Of the physicians who submitted medical reports, Drs. Guicheteau, Silkoff, Wilcox, Cander, Pacheco, and Tuteur diagnosed the miner with simple coal workers' pneumoconiosis. On the other hand, Drs. Repsher, Branscomb, Wheeler, and Scott concluded that the miner did not suffer from the disease. The remaining physicians noted the miner's smoking and coal mine employment histories, but provided no specific diagnosis of the presence or absence of coal workers' pneumoconiosis. Dr. Tuteur's conclusion that the miner suffers from coal workers' pneumoconiosis, as supported by the miner's autopsy, treatment, and hospitalization records, is found to be the most persuasive. Specifically, Dr. Tuteur issued the most recent report of record and had the benefit of reviewing the autopsy reports of all three pathologists as well as certain other medical records. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984) (greater weight may be accorded an opinion that is supported by more extensive documentation over the opinion that is supported by limited medical data).

It is further determined that the opinions of Drs. Repsher, Branscomb, Wheeler, and Scott, that the miner did not suffer from coal workers' pneumoconiosis, are entitled to little weight in light of the autopsy findings of simple coal workers' pneumoconiosis by all of the pathologists of record.

Although none of the physicians issuing medical opinions concluded that the miner suffered from complicated coal workers' pneumoconiosis, notably, Dr. Wheeler consistently observed a large node on the CT-scans he reviewed. He stated that the node measured 2.8 centimeters in greatest diameter based on his review of the August 23, 2000 CT-scan. Dr. Wheeler suggests that the node is the possible result of tuberculosis, malignancy, or some other granulomatous disease process unrelated to coal dust exposure. However, Dr. Wheeler's speculative statements as to the cause of the node observed on Claimant's CT-scan are undocumented and unreasoned on this record. In particular, there is no evidence in Claimant's hospitalization or treatment records that he suffered from tuberculosis, cancer, or any other disease process that caused development of the node. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988) (an equivocal opinion regarding etiology may be given little weight); *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984) (an unsupported medical conclusion is not a reasoned

diagnosis); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his diagnosis. The Board affirmed similar findings in *Keene v. G&A Coal Co.*, BRB No. 96-1689 BLA-A (Sept. 27, 1996) (unpub.), a copy of which is attached. In *Keene*, the Administrative Law Judge found that a CT-scan revealed the presence of an opacity exceeding one centimeter in diameter and that a preponderance of the medical evidence supported a finding of complicated coal workers' pneumoconiosis. In affirming the Administrative Law Judge, the Board noted that "Dr. Wheeler's opinion, that claimant's large opacity is compatible with tuberculosis, (did) not negate its compatibility with complicated pneumoconiosis."

In this case, Dr. Doberman's autopsy findings, which were based on observations and analysis of actual tissue from the miner's lungs including the large lesion, persuades the undersigned Administrative Law Judge that the node on the CT-scan is complicated coal workers' pneumoconiosis. Moreover, a September 2000 bronchoscopy was negative for the presence of "giant cells or granulomas." A cytology report produced negative findings for malignancy. Finally, although one physician mentioned the possible presence of sarcoidosis, the diagnosis was never confirmed and no physician unequivocally stated that the node in the miner's lung was due to sarcoidosis.

Viewing the medical data as a whole, including the chest x-ray studies, CT-scans, autopsy reports, hospitalization and treatment records, and medical opinion evidence, it is determined that the most compelling is the autopsy evidence. Based on first-hand observations of the miner's lung tissue, all three pathologists concluded that simple coal workers' pneumoconiosis was present. Moreover, Dr. Doberman, whose credentials are superior, specifically measured a 2.5 inch lesion of anthracotic scarring on his observation of the miner's lung. This is consistent with the large node observed on the CT-scans. For reasons previously set forth in this *Decision*, Dr. Doberman's autopsy report is accorded the greatest weight on this record and Claimant has established the presence of simple coal workers' pneumoconiosis under 20 C.F.R. § 718.202(a)(4) (2001) and complicated coal workers' pneumoconiosis under 20 C.F.R. § 718.304 (2001).

Because it is determined that the miner suffered from complicated coal workers' pneumoconiosis, the regulatory provisions at § 718.304 provide an irrebuttable presumption of total disability and death due to the disease.

Onset of Benefits

Because it is undisputed among the pathologists that the miner suffered from coal workers' pneumoconiosis at the time of his death, Claimant is entitled to benefits on the miner's claim on the date that the medical evidence establishes that he became totally disabled due to the disease. 20 C.F.R. § 725.503; *Carney v. Director, OWCP*, 11 B.L.R. 1-32 (1987). If the onset date cannot be determined from the medical evidence, then the payment of benefits should commence from the date the miner filed his claim. 20 C.F.R. §725.503(b). Finally, initial evidence of total disability due to pneumoconiosis does not necessarily establish the onset date; rather, such evidence only demonstrates that the miner became totally disabled due to the disease at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984).

In this case, the miner filed his claim for benefits in March 1998 and the first diagnosis of total disability due to coal workers' pneumoconiosis was provided by Dr. Guicheteau in his June 1998 medical report. Although Dr. Guicheteau diagnosed the presence of coal workers' pneumoconiosis based, in part, on a discredited chest x-ray interpretation, he also determined that the miner's coal mining employment history and qualifying blood gas test results supported a finding that the miner was totally disabled by the disease. *Morgan v. Bethlehem Steel Corp.*, 7 B.L.R. 1-226 (1984) (blood gas studies are relevant primarily to the determination of the extent of impairment, but such evidence may also indicate the presence of a disease process arising out of coal mine employment). Blood gas testing conducted from October 1998 through July 2001 consistently yielded qualifying values, except for the April 1999 test, which was administered while the miner was on a ventilator and, as such, it is not indicative of the miner's true lung function. Based on the foregoing medical evidence, it is determined that the miner became totally disabled due to coal workers' pneumoconiosis at some point in time prior to Dr. Guicheteau's June 1998 medical report. As a result, benefits will be awarded from the date the miner filed his claim for benefits in March 1998 through the month preceding his death, which is December 2001.

In the survivor's claim, where Claimant is an eligible survivor of the miner and entitled to benefits under the Act, as in this case, benefits must be paid beginning with the month of the miner's death but, in no instance, before January 1, 1974. 20 C.F.R. § 725.503(c) (2001). The survivor in this claim is entitled to benefits from January of 2002, the month in which the miner died. Accordingly,

ORDER

IT IS ORDERED that:

1) the claim for benefits pursued by Delores Ashmore on behalf of Merrill Lambright is granted and the payment of benefits shall commence as of March 1998 continuing until December 2001, to be augmented by reason of his dependent wife; and

2) the claim for benefits filed by Delores Ashmore, as a survivor of Merrill Lambright, is granted and the payment of benefits shall commence as of January 2002.

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Thomas M. Burke
Associate Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.